



# HealthChoice

## Network Provider Manual

# 2011

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## Network Provider Manual

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## **Introduction**

HealthChoice is a managed health care program providing comprehensive health and dental benefits to over 150,000 state, education, and local government employees and their covered dependents.

HealthChoice is administered by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB), an agency of the State of Oklahoma. The HealthChoice program utilizes a partnership approach among Providers, Members, and OSEEGIB in the delivery of health care services and products. This philosophy controls costs, assists in the provision of high quality health care and enhances provider/patient relationships. The HealthChoice benefit structure offers financial incentives to encourage Plan Members to utilize HealthChoice Network Providers exclusively.

The HealthChoice Network Provider Manual is a summary only and is not intended to be all inclusive. However, its contents should provide you and your business office personnel vital information regarding the most important aspects of participating in the Provider Network.

## **Member Handbooks**

A complete description of the plans offered by HealthChoice can be found in the member handbooks. The member handbooks for the HealthChoice health and dental plans can be accessed at the following websites:

<http://www.ok.gov/sib/documents/HealthHandBook.pdf>

<http://www.ok.gov/sib/documents/DentalHandbook.pdf>

## **HealthChoice Contact Information**

### **Oklahoma State and Education Employees Group Insurance Board (OSEEGIB)**

3545 N.W. 58th Street, Ste. 1000

Oklahoma City, OK 73112

1-405-717-8701 (local)

1-800-543-6044 (toll free)

[www.sib.ok.gov/providers](http://www.sib.ok.gov/providers)

### **Provider Relations Division**

3545 N.W. 58th St., Ste. 600

Oklahoma City, OK 73112

Network Management 1-405-717-8860 (local)

Research 1-405-717-8790 (local)

1-800-543-6044 (toll-free)

1-405-717-8977 (FAX)

### **Health Care Management Division (HCMD)**

3545 N.W. 58th St., Ste. 500

Oklahoma City, OK 73112

1-405-717-8879 (local)

1-800-543-6044 (toll-free), ext. 8879

1-405-717-8947 (FAX)

### **Health Education Lifestyle Planning (HELP, Wellness Division)**

3545 N.W. 58th St., Ste. 500

Oklahoma City, OK 73112

1-405-717-8991 (local)

1-800-318-2365 (toll-free)

1-405-717-8935 (FAX)

## **Third Party Administrators for HealthChoice**

### **Claims Administration: (Health, Dental and Life Claims):**

#### **HP Administrative Services, LLC (HP)**

P.O. Box 24870

Oklahoma City, OK 73124

Oklahoma City Area: 1-405-416-1800

All Areas: 1-800-782-5218

FAX: 1-405-416-1750

TDD Oklahoma City Area: 1-405-416-1525

TDD All Areas: 1-800-941-2160

Hours: 7:00 a.m. to 7:00 p.m. Monday through Friday (including state holidays)

Effective 10-18-10 7:30 a.m. to 6:00 p.m.

### **Certifications:**

#### **APS Healthcare**

P.O. Box 700005

Oklahoma City, OK 73107-0005

All Areas: 1-800-848-8121

FAX: 1-405-416-1755

TDD All Areas: 1-877-267-6367

Hours: 7:00 a.m. to 7:00 p.m. Monday through Friday (excluding state holidays)

### **Pharmaceutical Benefits Management:**

#### **Medco Health Solutions**

8111 Royal Ridge Pkwy

Irving, TX 75063

Attn: State of Oklahoma CST

All Areas: 1-800-903-8113

TDD All Areas: 1-800 871-7138

FAX: 1-972-915-2414

## Joining the HealthChoice Provider Network

The HealthChoice Provider Network is comprised of over 15,000 health care practitioners and facilities. Most providers who are licensed and/or certified in their particular state are eligible to participate in the Provider Network. HealthChoice Plan members have the ability to utilize health care providers from a wide range of specialties. The following is a list of providers eligible to participate in the HealthChoice Provider Network:

Ambulance	License Marriage Family Therapist
Ambulatory Surgery Center	Licensed Professional Counselor
Anesthesiology Assistant	Long Term Acute Care Facility
Audiologist	Medical Doctor
Birthing Center	Nurse Practitioner
Certified Nurse Midwife	Ocularist
Certified Orthotist	Occupational Therapist
Certified Prosthetist	Ophthalmologist
Certified Registered Nurse Anesthetist	Optometrist
Chiropractor	Oral Surgeon
Christian Science Nurse	Osteopathic Doctor
Christian Science Practitioner	Pathology (Individual)
Clinical Nurse Specialist	Pathology (Group)
Dentist	Perfusionist
Dialysis	Pharmacist
Dietitian	Physical Therapist
Durable Medical Equipment	Physician
Hearing Aid Vendor	Physician Assistant
Home Health Care	Podiatrist
Hospice	Psychologist
Hospital (Medical & Psychiatric/Substance Abuse)	Radiology (Individual)
Independent Diagnostic Testing Facility	Radiology (Group)
Infusion Therapy	Rehabilitation Facility
Laboratory	Skilled Nursing Facility
Licensed Alcohol and Drug Counselor	Sleep Study
Licensed Behavioral Practitioner	Speech Language Pathologist
Licensed Clinical Social Worker	Wig/Scalp Prosthesis

Contracts and applications are obtained online through a link on the HealthChoice Network Provider website Home Page, [www.ok.gov/sib/providers](http://www.ok.gov/sib/providers) or by contacting the HealthChoice Provider Relations Division.

The Network Contracts require Network Providers to make a reasonable effort to refer HealthChoice members to other Network Providers when additional consults are necessary. OSEEGIB believes this referral process is in the best interest of the Plan member and within the dictates of good medical practice. Plan members cannot realize the full benefit of the HealthChoice Health Plan unless they utilize Network Providers exclusively.

## **Provider Relations Division**

The HealthChoice Provider Relations Division is the primary source of information and assistance for Providers participating in the Provider Network.

Provider Relations is primarily responsible for:

- Performing the day-to-day duties necessary to manage the Provider Network including the distribution of contracts, applications, and all other documentation utilized to obtain and store accurate provider information.
- Maintaining the Network Provider database, which is used as the primary source of provider information for the Provider Self Service feature of the Provider website and the claims payment system?
- Handling inquiries from providers about contract terms, reimbursement, and basic claim issues, as well as, inquiries from members needing assistance with issues that involve Network Providers.

Provider Relations Division office hours are from 7:30 am to 4:30 p.m., Monday through Friday.

### **Provider Relations Division Contact Information**

3545 N.W. 58th Street, Ste. 600

Oklahoma City, OK 73112

Oklahoma City Area: 1-405-717-8790

All Areas: 1-800-543-6044

Fax: 1-405-717-8977

**NOTE: It is important for the provider to send all written inquiries regarding Contract information or any documentation intended for the Provider Relations staff, directly to the Provider Relations Division at the address or fax number referenced in this section of the Manual. If it is addressed to a third party administrator there may be a significant delay in receiving a response.**

## **Provider Self Service**

The *Provider Self Service* feature of the website is the primary method available to search for Network Providers. The information is updated frequently to ensure Providers have access to the most accurate information available. The *Provider Self Service* feature also allows Network Providers to review pertinent information regarding the claim submittal process including the Practice Identification Number (PIN), service, mailing, and billing addresses, phone numbers, specialties, and Network effective dates. Provider Self Service is accessed by clicking on the "*Provider Self Service*" link which can be found in the Provider drop down menu at the top of the page. The web address is [www.ok.gov/sib/providers](http://www.ok.gov/sib/providers).

## **Network Provider Termination**

The Network Provider Contract gives OSEEGIB the ability to terminate a Network Provider without cause upon 30-days notice. All HealthChoice Network Providers have the ability to terminate the Contract at any time provided a minimum of 30-days notice is given to OSEEGIB.

Letters of termination from the Network Provider and/or HealthChoice should be sent certified mail per the terms of the Network Provider Contract. The return receipt will serve as verification that the information has been received. The actual effective date of the termination will be 30-days from the date the termination letter is received in the Provider Relations Division of HealthChoice.

**Please make a reasonable effort to inform all of your HealthChoice patients about your termination so they can make informed decisions about future Provider utilization.**

## **Fee Schedule Requests**

OSEEGIB recognizes the need for obtaining fee schedule information in an effort to conduct financial impact assessments.

For your convenience, direct access to current HealthChoice fee schedule information is provided through the HealthChoice Network Provider website at <https://gateway.sib.ok.gov/feeschedule/Login.aspx>.

## **Member Responsibilities**

All HealthChoice members are encouraged to exclusively utilize Network Providers for the delivery of health care services. HealthChoice offers financial incentives for member compliance. When utilizing a HealthChoice Network Provider, the member is obligated to the following:

1. Providing evidence of coverage in the form of a HealthChoice ID card.
2. Assuming the financial responsibility of deductibles, copays, coinsurance and non-covered items.
3. Cooperating with the Provider in transactions involving any and all insurance carriers covering the member for services rendered.
4. Assisting with and adhering to all aspects of the benefits offered through HealthChoice.

A sample identification card for HealthChoice medical and dental benefits is available at [http://www.ok.gov/sib/Providers/Provider\\_Manual/Member\\_Responsibilities.html](http://www.ok.gov/sib/Providers/Provider_Manual/Member_Responsibilities.html).

## **Claim Filing Procedures/Claim Payments**

HealthChoice Network Providers are required, under the terms of the Network Provider Contract, to file claims for HealthChoice members.

Claims should be submitted to:

HP Administrative Services, LLC  
P.O. Box 24870  
Oklahoma City, OK 73124

Correspondence should be submitted to:

HP Administrative Services, LLC  
P.O. Box 24110  
Oklahoma City, OK 73124

Acceptable claim forms are:

CMS 1500  
UB-04  
American Dental Association 2006

For detailed information regarding how to file claims, consult the HealthChoice Provider Billing Guides online at [www.ok.gov/sib/providers/billingguides.asp](http://www.ok.gov/sib/providers/billingguides.asp).

Regardless of the claim form utilized by the provider, claims are processed according to the appropriate fee schedule.

## **ClaimLink**

ClaimLink is a valuable feature of the HealthChoice Network Provider Home Page. With ClaimLink, Network Providers have online access to check the status of medical and dental claims, to check deductible status, to confirm member eligibility and access claim editing rationale. ClaimLink does not currently provide editing rationale for outpatient facility claims. Outpatient facility claims are edited using the Outpatient Code Editor (OCE) as published by the Center for Medicaid and Medicare Services (CMS).

In order to ensure privacy, first-time users must register and create a User ID and Password. The provider's email address and TIN will be required to register. The User ID and Password is necessary for future access.

Access to ClaimLink is available on the Network Provider Home Page at [http://www.ok.gov/sib/ClaimLink/ClaimLink\\_for\\_Providers/index.html](http://www.ok.gov/sib/ClaimLink/ClaimLink_for_Providers/index.html).

### ***Direct Data Entry***

Within ClaimLink, providers have the ability to submit individual claims without any intermediary software through the direct data entry feature. The direct data entry feature allows providers to submit individual medical, dental or hospital claims directly to the claims administrator. The provider receives an immediate response regarding the status of the claim with real time responses indicating if the claim has been paid, denied or suspended.

## **Electronic Claims Submissions**

### ***Clearinghouses***

Providers are able to submit claims electronically utilizing acceptable clearinghouses as identified by HP. Contact HP directly for more information.

All claims are paid directly to Network Providers as required under the terms of the Contract.

An example of the Provider Remittance Statement is available at <http://www.ok.gov/sib/documents/HCRemittance.pdf>.

HealthChoice Network Providers currently accepting Medicare assignment will receive direct claims payments.

### ***Electronic Funds Transfer***

Electronic Funds Transfer (EFT) is utilized for all provider payments. The EFT method of payment eliminates the need for the manual processing of checks. EFT also ensures security and expedites claim payments to the providers.

Checks and Remittance Advices are processed for Network Providers on a nightly basis. Payments are deposited into the provider's bank account the next business day. Remittance Advices are mailed to the provider from Oklahoma City the same day as the EFT deposit.

If you have questions or you need more information about EFT, contact HP for assistance.

### ***Combined Payments***

Combined Payments are utilized for all providers. Under the Combined Payments feature, all payments for a given day are combined into a single Remittance Advice which is issued to the provider on a daily basis. Combined Payments should facilitate the processing of claim payments by the provider.

If you have questions or you need more information about Combined Payments, contact HP for assistance.

## ClaimCheck and Clear Claim Connection

**ClaimCheck** is an editing software program which is used by HP Administrative Services (HP), the claims administrator for HealthChoice, to edit claims for coding discrepancies.

ClaimCheck was designed by McKesson Information Solutions, a leader in claims editing technology. This software is used to assure claims are properly coded using industry standard coding edits. ClaimCheck is designed to detect coding discrepancies automatically. Automated reviews improve accuracy and consistency in claims adjudication and leads ultimately to improved claim turnaround times. ClaimCheck utilizes National Correct Coding Initiatives (CCI), Current Procedural Terminology guidelines, as published by the American Medical Association, and the general standards of medical practice in editing claims. Editing guidelines established by the Centers for Medicare and Medicaid Services (CMS) are also included in ClaimCheck rules.

**Clear Claim Connection** provides specific detailed information regarding ClaimCheck's procedure code auditing software and how it evaluates code combinations during the processing of a claim. Clear Claim Connection allows the HealthChoice Network Provider online access to McKesson's claims editing rules and clinical rationale used in the auditing software.

**Billed charges, which are edited by ClaimCheck, are not the financial responsibility of the patient/member.** In the event you disagree with any determination made by ClaimCheck, please contact the claims administrator and provide documented information that supports your position. Supportive documentation should be sent to the correspondence address for the claims administrator.

You can access ClaimCheck and Clear Claim Connection, through ClaimLink. Access to ClaimLink is through a link on the HealthChoice Network Provider Home Page at [http://www.ok.gov/sib/ClaimLink/ClaimLink\\_for\\_Providers/index.html](http://www.ok.gov/sib/ClaimLink/ClaimLink_for_Providers/index.html).

## Coordination of Benefits

If a HealthChoice Plan member is covered by more than one group insurance plan, the HealthChoice Coordination of Benefits (COB) Rules provide a payment to the Network Provider from OSEEGIB in an amount that is equal to 100% of OSEEGIB's standard benefit (allowed charges) or the member's liability, whichever is less, when coordinating benefits among coordinating Plans.

According to HealthChoice COB Rules, HealthChoice Network Providers will not receive reimbursement from OSEEGIB, in excess of the allowed charge. When the HealthChoice Plan is other than primary, no additional benefits are payable to the Network Provider, and the HealthChoice member is not liable for any additional expenses that exceed the allowed expenses.

An unofficial copy of HealthChoice Rules and Regulations, which include the COB Rules, is available at [http://www.ok.gov/sib/OSEEGIB\\_Rules.html](http://www.ok.gov/sib/OSEEGIB_Rules.html).

## Provider Claim Appeals

Providers can appeal the processing of a claim by submitting a letter to HP Administrative Services at the address designated for filing claims (See page 7).

If the initial appeal is upheld and you have additional information to submit for review, a written request must be submitted to HealthChoice requesting another appeal of the claim payment. Submit the written request for an additional appeal to the Correspondence Address listed on page 7. All appeal rights expire one (1) year from the point that the claim has been processed and a decision has been made on the claim.

## Utilization Review

Each HealthChoice Network Provider is contractually obligated to cooperate with all utilization review procedures established by OSEEGIB.

### Certification

Certification is a medical review process that is performed to establish that a procedure, service or supply meets the Plan's guidelines for medical necessity. Certification only establishes medical necessity and does not verify a member's eligibility or guarantee the payment of Plan benefits.

- When certification is initiated and approved within the established time frame, and all other Plan rules and guidelines are met, your claim is paid according to Plan benefits and no penalty applies.
- When certification is not initiated and approved within the established time frame but is approved retrospectively, and all other Plan rules and guidelines are met, your claim is assessed a 10% penalty. **The member is not responsible for paying this 10% penalty.**
- When certification is initiated and denied, either prospectively or retrospectively, because medical necessity guidelines are not met, your claim is denied.
- When certification for diagnostic imaging is initiated and approved for a specific CPT code and the claim is submitted with a different CPT code, your claim is denied.

Once certification is approved, services and/or supplies can be provided. Please have the following member information available when requesting certification:

- Name and identification number
- Gender and age
- Member status (i.e., employee or dependent)
- Diagnosis
- Scheduled date of admission or service
- Planned procedures
- Provider name

**Certification by APS Healthcare is required for the following procedures even when HealthChoice is the second or third payor:**

- Inpatient admissions
- Transplants
- Selected outpatient procedures including:
  - Blepharoplasty
  - Breast implant removal
  - Breast reduction
  - Panniculectomy
  - Rhinoplasty
  - Scar revision
  - Surgical treatment of varicose veins
- All observation stays greater than 24 hours (with the exception of an observation stay less than 24 hours without room and board charges)
- Exhaustion of Medicare lifetime reserve days

- Diagnostic imaging procedures including:
  - Sinus CT and MRI
  - Spine CT and MRI
  - Orbit and Ear CT and MRI
  - Head/Brain CT and MRI
  - Upper Extremity MRI
  - Chest CT including Spiral CT (RAD)
  - PET Scans

Providers can contact APS Healthcare toll-free at 1-800-848-8121 and use the VoiCert automated phone system to request certifications. Call APS and follow the telephone prompts to leave certification requests through VoiCert.

**Helpful Hint:**

When HealthChoice is the second or third payor, (other group health insurance or Medicare primary) certification is required for the admissions and procedures listed above. This process helps protect both the provider and the member in the event the primary payor denies coverage or applies coverage exclusions or limitations. For example, the primary carrier denies a service that is covered by HealthChoice. If the provider did not request certification prior to the admission or procedure, HealthChoice may cover the service but a 10% penalty will apply to the provider even if the service meets certification requirements and is medically necessary as determined by OSEEGIB. This process will also be applicable when a member exhausts benefits under CMS and HealthChoice pays in the primary position and may pay any additional benefits.

**Certification by the Health Care Management Division at OSEEGIB is required for the following services:**

- Botox injections (non-cosmetic)
- Chiropractic therapy –visits exceeding 20 per calendar year must be certified; limited to 60 visits per calendar year.
- Dental accidents
- Durable medical equipment (DME)
- Enteral feeding
- Hearing aids – covered only for dependent children up to age 18
- Home health care – may be approved for up to 100 visits per calendar year
- Home infusion therapy
- Hospice – requires physician statement of life expectancy of six months or less
- Mental health home services – covered only for six biologically-based diagnoses
- Non-emergency ground or air ambulance
- Occupational therapy - visits exceeding 20 per calendar year must be certified; limited to 60 visits per year
- Oral Surgery – outpatient
- Orthotics and prosthetics
- Orthotripsy
- Outpatient hyperbaric oxygen therapy
- Outpatient mental health/substance abuse treatment – visits exceeding 15 per calendar year must be certified; limited to 26 visits per calendar year
- Physical therapy -visits exceeding 20 per calendar year must be certified; limited to 60 visits per calendar year
- Speech therapy – visits exceeding 20 per calendar year must be certified; limited to 60 visits per calendar year.
- Temporomandibular Joint Dysfunction (TMD) treatment
- Visco supplementation injections of the knee

Providers can contact HealthChoice Health Care Management at 1-405-717-8879 or toll-free 1-800-543-6044, ext. 8879.

## Inpatient Certification

The Network Provider and the member equally share the responsibility to obtain certification for hospital admissions. OSEEGIB requires all non-emergency hospital admissions be certified at least three working days prior to the actual admission (this excludes maternity admissions for the delivery of a newborn, which do not require certification). Emergency admissions require notification within 24 hours (one working day) of the actual admission date. Holiday or weekend admissions must be certified by the first working day following the date of hospital confinement. The hospital, physician and the member will receive a letter verifying certification.

Upon initiation of the certification process, a reference number will be assigned to the particular case (assignment of a reference number does not complete the certification process or guarantee benefits). Utilization Review staff members will review medical information pertaining to the patient. If the initial requirements are met and the certification is approved, the 10% penalty will not be assessed to the claim payment.

APS will update the progress of the patient at established intervals during the concurrent review process. The medical necessity of additional inpatient days is also determined during the concurrent review process. APS performs retrospective reviews/appeals. A retrospective review/appeal could be warranted in the following situations:

- Admission denials
- Surgical procedure denials
- Additional inpatient days denied

**All hospital confinements billed as “observation” must be certified within one working day with the exception of observation stays less than 24 hours without room and board charges.** When certification is not initiated and approved within the established time frame, but is approved retrospectively, and all other Plan rules and guidelines are met, the claim payment is assessed a 10% penalty. **The member is not responsible for paying this 10% penalty.**

Confinements billed as “observation”, in which room and board charges are incurred, will be paid based on inpatient benefits if the stay is certified. Claims submitted for certified inpatient hospital admissions with a duration of less than 24 hours will be processed utilizing benefits for outpatient hospital services (unless room and board charges are incurred).

## **Facility Dispute Resolution Procedures**

This procedure describes the method of initiating any disputes related to a facility's participation in the HealthChoice Provider Network. A complete description of the dispute resolution process exclusive to Network Facilities is located on the HealthChoice Network Provider Home Page at <http://www.ok.gov/sib/documents/FacilityExternalDisputeResolutionProcedures.pdf>.

To initiate the dispute resolution process, the provider must request and complete a HealthChoice Facility External Dispute Resolution Procedure Form which is available through the Legal Division by contacting Rhonda Tollers at 1-405-717-8729 or toll free 1-800-543-6044, ext. 8729.

## **HealthChoice Pharmacy Benefit**

The member is responsible for the appropriate copay or the actual cost of the prescription; whichever is less, when a Network Pharmacy is utilized. Only the costs of generic medications are covered unless there is no generic equivalent available. HealthChoice is a generic mandatory plan. If a generic medication is available, but the member requests the brand name equivalent, the member will be responsible for the copay amount plus the cost difference between the brand name medication and the generic equivalent. Some medications require prior authorization or may have quantity limits. Please contact the Pharmacy Benefits Manager, Medco at 1-800-903-8113 for information regarding quantity limits and to obtain prior authorization.

A list of preferred medications is included in the HealthChoice Select Medication List. A copy of this medication list is available on the Network Provider website at <http://www.ok.gov/sib/Providers/>.

### ***HealthChoice Select Medication List (HSML)***

The HealthChoice Select Medication List is based on optimum therapy strategies and the evaluation of clinically equivalent medications. These evaluations are performed by the pharmaceutical consultant for OSEEGIB and the clinical staff of the pharmacy benefits manager. A list of preferred and non-preferred medications has been established and members obtain preferred medications (medications included on the Select Medication List) by paying the cost of the medication up to a \$30 maximum if the cost of the medication is \$100 or less. If the cost of the preferred medication is over \$100, the member pays 25% of the cost up to a maximum of \$60.

Members obtain non-preferred medications (medications not included on the Select Medication List) by paying the cost of the non-preferred medication up to a \$60 maximum if the cost of the medication is \$100 or less. If the cost of the non-preferred medication is greater than \$100, the member pays 50% of the cost up to a maximum of \$120.

## **Prior Authorization Process for Non-Preferred Medications**

Prior authorization is required when a provider deems it necessary and appropriate to utilize a medication that is not contained in the Select Medication List. The prior authorization process is used to establish that a particular case meets clinically driven, medically relevant criteria before the medication is approved for coverage at the preferred rate.

The following process will be initiated for providers requesting prior authorization for a non-preferred medication at the preferred rate:

1. The provider's office should contact Medco at 1-800-753-2851. Please have the Member ID number (Social Security Number) and the medication name and fax number ready to give to the Medco representative.
2. Medco will fax a prior authorization form to the provider's office. This form should be completed at the provider's office. Call Medco at 1-800-753-2851 to obtain the appropriate fax number.
3. The provider's office will receive a fax from Medco which will supply notification of the review results.
4. If the medication is approved for coverage under the preferred rate, the approval is loaded into Medco's system within 24 to 48 hours. Written notification of the approval is faxed to the provider's office and sent to the member within 24 to 48 hours. If a non-preferred medication is not approved through the prior authorization process, written notification is also faxed to the provider and sent to the member within 24 to 48 hours.

For additional information about the HealthChoice pharmacy benefit reference the Health Plan Handbook at <http://www.ok.gov/sib/documents/HealthHandBook.pdf>.

## **Medicare Part D**

HealthChoice was awarded a contract by the Centers of Medicare and Medicaid Services to provide Medicare Part D benefits as an Employer Prescription Drug Plan (PDP) beginning January 1, 2006. HealthChoice is one of only four public sector plans in the country to offer a Medicare Part D employer PDP. An example of the Medicare Part D Identification Card and the Medicare Pharmacy Coverage Determination Request form is available online at [http://www.ok.gov/sib/Providers/Provider\\_Manual/Medicare\\_Part\\_D.html](http://www.ok.gov/sib/Providers/Provider_Manual/Medicare_Part_D.html). This document is completed by the provider if a medication is not included on the medication formulary list established by HealthChoice.

## **Dental Pre-Estimate**

A dental pre-estimate is an itemization of proposed dental services and the expected charges before dental services are performed. A pre-estimate is not required, but it is recommended if the dental treatment plan proposed by the dentist is expected to cost more than \$200, as it will explain how much the member is expected to pay. It should be identified as a pre-estimate and submitted in the same manner as a standard paper dental claim.

**A dental pre-estimate should not be confused with prior authorization.**

## **Maternity Program**

### **“Mommy and Me”**

The Mommy and Me maternity health care program has been developed to assist pregnant Plan members in having a healthy pregnancy. This program is not a replacement for medical care by a physician or a substitute for regular prenatal visits. The Mommy and Me program endeavors to promote the merits of good general health and wellness by acting as a resource for current information regarding pregnancy, childbirth, and the baby. The assistance of Network obstetricians and family practice physicians in identifying and referring expectant mothers in the first trimester of pregnancy is crucial to the overall effectiveness of the Mommy and Me program. Through this maternity program, HealthChoice wants to encourage members to take an active part in their overall care during pregnancy.

For more information regarding the **Mommy and Me** maternity program, members and providers may call 1-800-475-9926 or go online at [http://www.ok.gov/sib/Member/Wellness/Mommy\\_and\\_Me/index.html](http://www.ok.gov/sib/Member/Wellness/Mommy_and_Me/index.html).

## **Osteopathic Manipulation, Speech Therapy, Physical/Occupational Therapy and Chiropractic Therapy Guidelines**

Benefits for these services are subject to the following guidelines:

20 visits will be allowed per calendar year without certification. A maximum of 60 visits will be allowed each calendar year.

Treatments that exceed 20 visits per calendar year must be referred to the Health Care Management Division (HCMD) and the appropriate professional consultant for review. Manipulative therapy performed by an osteopath or medical doctor is also subject to these guidelines.

Referral forms for chiropractic, physical medicine, occupational therapy and physical therapy must be completed and submitted to HCMD to initiate the certification process. The professional consultant could subsequently request additional documentation from the provider. The appropriate forms are available online at [http://www.ok.gov/sib/Providers/Provider\\_Forms/index.html](http://www.ok.gov/sib/Providers/Provider_Forms/index.html).

The following information will be requested on the referral form:

- Diagnosis
- Summary of the case
- Approximate length of time treatments will be necessary
- Long/Short term goals

The following information may be requested by the professional consultant to support medical necessity:

- Complete treatment plan
- History and physical
- Assessment of the patient's response to treatment as determined during the initial examination and reevaluation
- Progress notes